The community clinics: an observation

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INTRODUCTION:

"Either you take us to the Upazila Parisad office or erect a wall here separating us from the Health wing" -an Upazila Family Planning Officer (UFPO) commented to a researcher about a decade back (Chowdhury, 1990). The study revealed an undercurrent of hostility between the two divisions: Health and Family Planning wings of the Ministry of Health and Family Welfare. It was found that a sense of mutual suspicion and mistrust exist between the workers of the Health and the Family Planning wings which tended to affect their performance. However, years have passed and the scenario have changed. The recent fiveyear plan (1998-2003) of the Ministry of Health and Family Welfare (MOHFW) Government of the People's Republic of Bangladesh, has drawn a sectoral programme, popularly known as HPSP (Health and Population Sector Programme). This has been a new step towards sectoral reform. One of the unique reform is the organisational unification of the health and family planning wings to provide a range of health and family planning services through an effective and financially sustainable system capable of delivering an Essential Services Package (ESP). The ESP is designed to address the health needs of families in a comprehensive manner. The goal is to contribute to the vulnerable segment of the population, such as women, children and poor. ESP services are grouped into five major areas:

a. Reproductive health care
b. Child health care
c. Communicable disease control
d. Limited Curative Care
e. Behaviour Change Communication (BCC)

At the rural community level, the ESP is planned to be delivered in an integrated way from a static centre, called a community clinic (CC), built for an average population of 6,000. At present, the community level health and family planning service delivery system is dependant on two mechanisms: I) Home visit by Health Assistant once a month per household, and FWA (Family Welfare Assistant) once bi-monthly per household. ii) Makeshift satellite clinics/EPI outreach centres.

Each field worker usually covers 5000 people. This system is labour-intensive and costly. Moreover, the scope of the service is limited with such a makeshift arrangement and home visitation approach. It is reported that the frequency of the field worker's visit per household does not adequately meet the client's need for health care as it is made once a month or less. Therefore the gap between subsequent visits is quite long. In the view of the above-mentioned limitations of the home based service delivery, the HPSP has proposed this integrated package of health and family planning services-ESP. Community clinic will be the permanent outlets and the first tier for ESP delivery at the community level. The other outlets for ESP delivery in rural settings are Union Health and Family Welfare Centre (UHFWC) at the union level and Upazila Health Complex (UHC) at the Upazila level. The community clinics are designed to operate jointly by the government and the community. A committee for site selection will be formed at the Upazila level, headed by the Upazila Health and Family Planning Officer (UHFPO), for finalising the site selection procedure according to the MOHFW's guidelines. The community will select the site and donate five decimals of land on which the government will construct a building of 460 square feet floor space with provision for three rooms, one toilet and an attached tube well. The community will constitute a committee (Community group) to oversee the construction of the clinic and to look after the maintenance and security of the infrastructure. Besides construction of the building, the government will monitor services and provide technical supervision, medicines, equipment, furniture and manpower. These clinics will remain open on all working days (not less then 40 hours per week), and are run jointly by Health Assistant (HA) and Family Welfare Assistant (FWA). Therefore the basic characteristics of a community clinic are as follows (Islam Z. et al: 1999):

a. The community clinic is the basic unit (first level) of ESP delivery at the community level.

b. One community clinic for an average of 6000 people.

c. The clinic should be located in a centrally convenient location for the defined population.

d. Location of the clinic should be considerably away from the graveyard/cemetery, crematory and riverbank.

e. 80% of the population should live within a 30 minutes walking distance from the community clinic.

f. Services delivered by home visit will be gradually replaced by provision of services at the community clinic.

g. A team, comprising of one FWA and one HA will be the core service providers of the community clinic

h. Each team must have at least one female worker.

i. Services will be made available on every working day.

j. Limited domicilliary services will be offered by the community clinic workers to the groups or individuals at risk, e.g., dropouts, handicaps, people living in remote areas etc.

k. Existing satellite clinics and EPI outreach sites will be gradually reduced, keeping pace with the operationaization of the community clinic.

l. FWV of the union will render services (IUD/injectable) at a regular interval, i.e. at least once a month.

It was planned that for the first phase (May 1999-July 2000) 6000 community clinics will be constructed. But the actual construction of the community clinic is far from the target. Even most of the constructed community clinics could not be open for service due to various reasons. This study looked at the current situation of the already opened community clinics.

Aim of the study:

The study was carried out to know:

1. What are the providers perspectives about the community clinic initiative?
2. What are the client's perspectives about the community clinic initiative?
3. What type and level of training did the providers received for their job?
4. How the community clinic is managed and supervised?

5.What is the role of community clinic committee?

6. How much is the involvement of NGOs in this initiative?

Methods

Two community clinics were observed, one was in the Kalihati Upazila in Tangail district and the other was in the Kapashia Upazila of Gazipur district. These are the two earliest opened community clinics of the country. Both were opened in the later half of the year 2000. Following tools were used to gather information:

a) Open ended in-depth interview was conducted with the following concern persons:

Persons	Number
Upazila Health and Family Planning Officer (UHFPO)	2
Medical Officer Mother and Child Health (MOMCH)	2
Family Planning Officer (FPO)	2
Family Planning Inspector(FPI)	1
Health Assistant (HA)	2
Family Welfare Assistant (FWA)	2
Clients (Ten from each centre)	20
Community Clinic committee member (Two from each clinic)	4
NGO personnel (Two from each area)	4

b) Centre observation- Structured check list was used.

Researcher himself and a research assistant conducted the interviews and the observations. Data were collected during February 2001.

Results

A. Providers perspectives about community clinic

It was found that all the service providers including field staff and Upazila health complex staff members consider community clinic as a good initiative of the government. As one Upazila Health Administrator stated, " This is a new era in our health delivery system. Now health service is at people's door step. This will be very helpful for the poor people of our village."

Benefits

The providers mentioned the following benefits of the clinic:

1. The major benefit of community clinic is that now it is possible to give services from one stop and there is no need for house to house visit. The field staff said that the domiciliary service was a laborious and time consuming activity, but now that they can sit under a roof and provide service to the clients in a peaceful manner .

2. Most field level staff (HA and FWA) think that community clinic initiative has lifted their social prestige. As one of the Health Assistant (HA) said, " I am working as a HA for the last 17 years and had to walk door to door under the hot sun or heavy rain. Sometimes people were irritated to see me in their house and asked me to come some other times. I felt insulted. Whenever the house owner wanted he could cancel the EPI centre. But now I have a fixed place. There is no need to run people's door to door. Now I am honoured by the villagers."

3. Some field workers said that they feel satisfied to work in community clinic because now they can offer some direct service to the people, while previously they mainly used to give health education to the people. One HA said; "Previously I used to ask people about their health condition, wanted to know whether anybody is suffering from diarrhoea or fever. People would then say, what is our benefit telling you our

health problems because you could not give us anything, you just talk. Now I do not just talk but also give some medicine."

4. Field level staff also said that by working with the Health and Family Planning staff together in the clinic they could mutually benefit from each other. One FWA said, "It is good that now we can work together. We can learn from each other. We jointly can give service to the people."

5. The Upazila health complex staff, particularly the UHFPO and MOMCH said that the community clinic would help them in supervising the field staff. MOMCH of one Upazila mentioned, "Previously it was difficult to trace the FWA or the HA in the field. As they were running from house to house, it was not possible to locate them. Now if I go to the community clinic I can immediately oversee their work."

6. The Upazila health complex staff also think that if the community clinics work properly then a good referral system can be built. Patients could be identified in the grassroots level and referred to tertiary centres when necessary.

Problems

Providers, however also identified some problems of community clinic:

1. The main problem they mentioned was the irregular and inadequate supply of medicines. In the two clinics that were examined in this study, medicine supply was found to be very irregular. In the beginning both the community clinics got supply from the Upazila health complex but the supply was finished within about two months. After that there was no regular flow of medicines from the government. After the government stock of medicine was finished in Kalihati the community clinic group arranged some essential drugs through the fund raised by the committee members (They raised about 500 Taka), that was also finished within few weeks. In Kapasia no such arrangement was made. So it had to wait for few months for the next government allocation of medicines. As a result most of the time the clinics were running short of

medicine. This was identified by the clinic staff members as the most critical problem of the clinic.The FPO of Kalihati said, "For the first time after the clinic was opened we received a special supply of medicine but after that there was no supply for the clinic at all. Now when the clinic gives us indent we try to give medicines from which we have little excess in our regular Upazila health complex stock. In our area construction of three more clinics is over but we are unable to open those because of the lack of medicine supply."

2. The providers, mostly the field level ones also complained about the training they received for ESP. It was found that most of the staff members received training regarding ESP, which was organised at district level for both clinical and nonclinical service providers. Training period ranged from 5-21 days. Training was not particularly on community clinic but on ESP in general. The UHFPO and medical officer received short training for five days. Though the Upazila level staff were found more or less satisfied with the training but the field staff, like HA and FWA who received a training for 21 days were found very dissatisfied with the training. They said the training was not satisfactory both in terms of content and session arrangement. They complained that they were not adequately trained for the skills that they needed most. As one HA stated, "Previously we were not involved in curative treatment but now in the community clinic we have to give treatment. But we face a great problem in this because we were not properly trained with the treatment procedures. They just mentioned the name of the drugs for certain diseases but did not tell about the dose or side effects properly. We have the needle and thread in our clinic but we were not trained how to give stitch. I am therefore not at all confident about the job that I am doing."

The staff also complained about the way those training sessions were organised. A large number of trainees attended a training session where training material and space were not adequate, so most of the trainees fail to receive the messages.

One FWA said, "They were showing how to check the blood pressure. Fifty of us was watching this from a distance, I even could not touch the BP machine. How is it possible to learn something in this way?"
Another HA said, "We were given lecture one after another and didn't find time to digest any of those."
As a result most of the field staff avoid giving those services on which they do not have confidance.

3. Staff members complained about the insufficient supply of materials, particularly register books and papers. As a result the recording system of the clinic activities are remaining very poor.

4. Some staff complained that because of the community clinic activity their workload was increased.

5. The staff complained that the community clinic group was inactive. Though the main idea was that the community will take active part in the functioning of the clinic and the community group will supervise the functioning of the project, but in reality this was not happening.

6. Staff members also complained that the site selection for the clinic was also faulty. For Kalihati the clinic is near a big bazar, so it is difficult to maintain a target population, people coming to the bazar from different places enters in the clinics. As a result, it is difficult to maintain a particular target population for the clinic. In Kapasia, the clinic is built on the other side of a canal and it is connected by narrow bamboo bridge, which makes it difficult for women with children and also for elderly people to come across. Moreover, the clinic is very close to a pond and the ground is eroding, so in course of time it runs the risk of collapsing.

B. Client's perspective about the community clinic

It was observed that a number of patients come to the centre for services, about 40 patients a day mostly women and children. The respective staff mentioned that the number of patients were double in the initial stage of the clinic. They think the number declined mainly because of the lack of medicines in the centre. Following views were expressed by the clients of the community clinics:

1. Most of the clients appreciated the community clinic initiative, because it brought the health services in an accessible place very close to their home. As one client who lives half a kilometre from the clinic said, "Now we will not have to travel a long distance for health service, the clinic is now almost at my door step."

2. The clients mentioned about the benefits of getting multiple service from one stop. Clients said that they were happy since they would not have to go to different places for health and family planning service. Moreover, men, women and children get service from the same spot.

3. The client were pleased with the easy availability of the health and family planning staff. One woman said, "Previously I had to wait for the visit of the family planing sister to discuss about my complaints but now I can come any time to the clinic and talk to the sister here."

4. It was revealed that the clients were not at all aware about the role of community in running the clinic. They are also not aware about the existence of the community clinic committee.

Complaints

1. The clients mostly complained about the lack of medicines in the clinic. One old man angrily stated, "I am suffering from my eye problem for many days, I came here two more times but they said that medicine was finished. What is the use then to build up a building if there is no medicine."

2. Some of the clients said that the clinic is not open everyday of the week. Some time they came to the clinic, waited for some time but no staff came and it did not open at all.

3. Few clients said that they would prefer to have a qualified doctor in the health centre, rather a HA or FWA.

C. Management issues

Various management issues were explored.

1. Opening and closing time of the clinic:

According to the respective HA and FWA they usually open around 9.00 a.m. and close around 3.00 p.m. Though in actual observation the clinic was found to open much later and closed earlier. There were some practical problems also for opening the clinics on time. For example, in the clinic of Kapasia Upazila the HA, FWA live near Kapasia bazar and there is no good transport from there to the clinic. The bus which is the only transport comes after one/two hours. As a result the HA and FWA is always late in the clinic.

2. Work plan:

According to the proposal the HA and FWA are supposed to work in the field regularly for certain time. This is to give domicilliary services to individuals like dropouts, handicaps, people living in remote areas etc. However, it was found that the field work was not well planned. Some of them said that they go twice a week, some

said once a week. The HA and FWA also could not particularly say about their field activity plans.

3. Clinic in charge:

This was found that HA was the in-charge of the clinic, he kept the key of the clinic and also of the file cabinet where registers, medicine and other materials were kept. HA of Kalihati thought that he helds one step higher position then the FWA. Though there is no official declaration in this regard but it seemed that both HA and FWA agreed upon this arrangement.

4. Reporting and supervision system:

There is no regular reporting system. Though the clinic is supposed to send a regular monthly report to the Civil Surgeon office but they do not do it regularly. The supervision mechanism of the clinic was also not very strong. The FPI and MOMCH are suppose to visit the clinics in certain interval but it was found that the visit was also not regular. During the centre observation of two places no supervisor was found to visit the clinics. The field staff also felt that if they used to get feedback from their supervisors then they would be more benefited. One FWA said, "There is no routine visits by the supervisors, whenever they think they come. It would have been better if they would come more frequently."

5. Maintenance of registers and equipment:

During centre observation following registers were found in the clinics:

Kalihai clinic: stock register, patient register,brth/death register, attendance register, committee notice khata, visitors book, and fund raising Khata.

Kapasia clinic: EPI register, stock register, follow-up register, attendance register, notice khata, EPI tally sheet, and GR form.

The staff could not explain the dissimilarity of the registers in two Upazilas. However, it was found that the most registers were either filled up irregularly or incompletely.

Following euipments were available in both the clinics:

- Blood pressure machine, stethoscope, scissors, needle, cotton, stove, and harricane.

Although during centre observation no one was seen to use any medical equipment for patient examination.

6. Session management:

The patients are mostly concentrated in a particular time of the day, around 10 a.m. to 12 noon. During that time the centre become chaotic. All the patients gather around the table of FWA or HA. They mostly ask for medicine. Failing to control the patient flow the staff members loss their temper and sometimes become rude to the patients. The staff members do not have an assistant to control the clients. There is no waiting room or places for the attending clients.

7. Cost sharing:

Most of the health and family planning staff commented that they were in favour of charging some fee for the services offered in the clinic. They emphasised that this was necessary for the sustainability of the clinic. Most of the clients were willing to pay for the services if it was cheap. According to the clients a service charge of about Taka 3-5 would be affordable.

D. Community clinic group

The unique feature of the community clinic initiative is the participation and role of community people in managing the clinic. According to the guideline each clinic should have a committee or community group as a partner to government in managing the clinic. It was found that both the community clinic had groups, although the activities of the group was found irregular and disorganised. Though the concerned persons of the community clinic were aware about the existence of the group most of them failed to name and identify the group members. After asking a number of respondents it was possible to find out the list of the group members. In one clinic there was a community group of nine members, in which principal of the local private

college was the chairman and the health assistant was the secretary. The members include, two union parisad members, three school teachers, one librarian of the college, and one post master. The land for that clinic was given by the local private college authority. The other clinic has a group with seven members. In that clinic the land was given by a doctor, who was born in the same locality but lives in Dhaka. The chairman is a local businessman, who is the brother of the doctor who has given the land. The other members of the group include, health assistant, family welfare assistant, village doctor, two union parisad members and a school teacher. Ideally these members are supposed to sit every month and discuss the ongoing activities of the community clinic. They are also supposed to supervise the functioning of the clinic and take steps when necessary. However, none of these two community groups was found active in this regard. They did not have any regular meeting since the opening of the clinics. Although the group in Kalihati was found relatively better functioning than the Kapsia one. In Kalihati the group had some meetings (though irregular) and also took some new steps. For example, when the supply of medicine by the government was exhaused the group members raised a fund themselves and bought some medicines for the clinic. But that initiative did not work further. This group also appointed an Aya for the clinic at the rate of Tk. 100 per month. The *Aya* informed that she did not receive any payment so far.

In Kapasia, group meetings were held in the initial months of the clinic but that didn't continue. The group tried to raise fund by issuing health card on payment of Tk. 10 each but due to the protest of the clients the initiative was discontinued. This group didn't take any other programmes. There was no fund raising initiative for purchasing medicine. One of the community group member, who is a village doctor said, "Committee members do not take much interest. They do not want to give time. Initially they were involved but afterwards they rarely sit together."

E. Involvement of NGO

It was revealed that involvement of NGO in the community clinic initiative is negligible and not well defined. The staff members including the field and Upazila health complex were found unaware about the role of NGOs in the community clinic.

Most staff members said that they did not see any specific involvement of NGOs in the community clinic project and also not sure when and how the NGOs were going to be involved in this matter. BRAC has its activity in both Kalihati and Kapashia areas and there is one small NGO called Society for Social Service (SSS) working in Kalihati area and the other in Kapashia called *Palli Mangal Kendra*. Staff members of these NGOs also acknowledged that they were not directly involved in the activities of community clinic. The manager of BRAC rural development programme stated, "Nobody from Upazila level or field level government staff asked for any help from us, and we were also not directed by our organisation to be involved in the process of community clinic establishment. We are, in fact rather confused about our role in the clinic." But all these NGOs mentioned that they have fieldbased health programme and community health workers who help in various government health programs including EPI, TB and Leprosy control programme, polio eradication programme etc. These may indirectly help in functioning the community clinics. This was however found that the NGO workers are eager to get involved in the community clinic activities and the government staff also think that NGOs should more actively be involved in the community clinic process. ICDDR,B however, was involved in operational research of the community clinics during the initial stage of the project. (Islam, Z et al: 1999, and Sarker, S et al: 1999)

Discussion

Two of the clinics, opened in the first phase of the community clinic initiative were examined. Provider's and client's views about the community clinic, various management issues regarding the functioning of the clinic, functioning of the community clinic group, involvement of NGOs in community clinic activities were explored.

It was revealed that both providers and clients considered the community clinic as an excellent initiative of the government. Providers think that through community clinics a new era of health service delivery has started. It was expressed that delivering health and family planning services from one static spot and close to

people's door is beneficial for both providers and clients. The clients mentioned that through community clinic it was possible to receive services at their door step, moreover now they could approach the health and family planning staff whenever they wanted, while previously they had to wait for their home visits. The providers mentioned some additional benefits of the community clinic. For example, the field level staff thought that this had enhanced their social prestige as now they did not have to visit house to house to deliver service rather they had a static office from where they could provide services. Particularly the HAs mentioned that now they felt satisfied as they could now provide some curative services, while in the past they only used to give health education which they thought was not so useful. Upazila level staff mentioned that this made the supervision process easier, because it was easy to locate the field staff. They also said that through community clinic a good referral system could be made.

However, when the actual functioning of the community clinic was examined various problems, loopholes, and weaknesses revealed. According to the government guideline the community group was supposed to play specific role in selection of sites, donation of land and ensuring security and maintenance of the clinic, while the government inputs would include construction of the building, medical supplies, equipment, furniture, and manpower. It was revealed that though the government inputs regarding construction of the building, manpower and furniture was maintained accordingly, there were major irregularities and crisis in medical and equipment supplies. At the beginning of the community clinic there was a special allocation of medicines from the Upazila health complex. Later on no special arrangement was made to fill up the demand of medicines in the clinic. This created disappointment among the clients, and the staff members became also frustrated. In one of the clinics the community group has made some alternative arrangements for medicine supply by raising fund from the donation of the group members. But that was not a regular initiative, while the other community group did not at all take any action in this regard. Major gaps were identified with regards to the role of community group. The group did play any role in site selection and donation of land, but its role in maintenance of the clinic and also in other activities of the clinic was found to be poor. The

community group did not have regular meetings among themselves, the members did not have any distribution of tasks or work plans for proper functioning and sustainability of the clinic. No special initiative was taken by the committee except raising funds for purchasing medicine for the clinic of Kalihati Upazila. The committee could not appoint an *aya* to assist the FWA due to fund crisis. In comparison to the committee in Kalihati, the group in Kapasia was found to be poorly active. The community group of the clinic in Kapasia did not take any particular steps for the functioning of the clinic. Accountability and community awareness about the community clinic committee were found lacking. The clinic staff also expressed their disappointment about the training they received for ESP. They complained that they were not properly trained for the job they were doing. The training on prescribing drugs was incomplete and inadequate. Moreover a large number of trainees got training with a few number of training materials and in a small space. As a result in was not possible to internalise the training contents. The field staff, therefore, felt that they were lacking the skill to run a community clinic. Gross irregularity was also observed in the centre management. The opening and closing time of the centre was not properly maintained as per the official rule. There was no work plan of the concerned staff, reporting and supervision system was found to be poor, and registers and equipment were poorly maintained. There was confusion about who was the in charge of the clinic, and sessions were also chaotically organised. The involvement of NGOs in the whole process of the clinic was also found minimal. Though different NGOs including BRAC were active in the study area, they hardly involved in the clinic activities. They said that as they were not asked by the government or the community to join in the community clinic activity and also were not directed by their respective organisations to get involved in the process they remained passive in the initiative. They were confused about their role in the community clinic.

We observed that, although the community clinic appeared to be a promising initiative to all concerned, it failed to achieve its goal mainly due to failure of the stakeholders like the government, community, and the NGOs in performing their proper role. There is also lack of coordination, motivation, and preparation of the

stakeholders regarding their role in managing and maintaining the function of the community clinic.

Although the results of this study that observed only two clinics can not be generalised, but a pattern of functioning of clinics can be identified. Moreover, this should be noted that the two clinics that have been observed are the earliest opened clinics. So, they are functioning for a longer period and expected to be to relatively experienced clinics. However, community clinic is a relatively new initiative. It is, in fact, in its transitional stage. Both providers and clients have accepted and appreciated the initiative. There are also partial participation of the various stakeholders in the initiative. Therefore, if its weaknesses are identified on time and steps are taken to rectify those it could be a successful programme. Following are some specific recommendations in this regard:

(1) Adequate and regular supply of medicines and other materials should be ensured.

(2) Initiatives should be taken to increase the skill of the field staff.

(3) Staff should have some scope to learn by doing.

(4) Steps should be taken to activate the community clinic group.

(5) Community should be made aware about their role in the functioning of the clinic.

(6) Proper mechanism of management and supervision of the clinic should be developed.

(7) NGOs should be more actively involved in the clinic initiative.

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